TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TMH PHYSICIAN ASSOCIATES, PLLC
DR JENNIFER WAGNER

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-21-0116-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
SEPTEMBER 25, 2020

REQUESTOR'S POSITION SUMMARY

"Texas Mutual has denied this bill and the request for reconsideration because they state the CPT codes billed do not accurately represent what is documented in the progress notes. Our coding department has reviewed this and they maintain that these codes are in fact correct."

Amount in Dispute: $302.00

RESPONDENT'S POSITION SUMMARY

"Medicare Claims Processing Manual-Chapter 12 modifier 78 is used for return trips to the 'operating room' for a related procedure during a postoperative period. An operating room is not consistent with POS 11. POS 11 per Medicare is an office setting location."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 20, 2020	HCPCS Code J0702	$15.00	$0.00
	CPT Code 20550	$287.00	$0.00
TOTAL		$302.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.10, effective April 1, 2014, sets out the healthcare providers billing procedures for required billing forms and formats.
3. 28 TAC §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

Issues

Is the requestor due reimbursement for professional surgical services rendered on February 20, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $302.00 for CPT codes 20550 and J0702 rendered on February 20, 2020.
2. The respondent denied reimbursement for the disputed services based upon CAC-P12, CAC-16, 225 and 892 (description listed above). The respondent wrote, "Medicare Claims Processing Manual-Chapter 12 modifier 78 is used for return trips to the 'operating room' for a related procedure during a postoperative period. An operating room is not consistent with POS 11. POS 11 per Medicare is an office setting location."
3. To determine if the respondent's denial of payment is supported, the DWC refers to the following statute:
   - 28 TAC §134.203(a)(5) states, "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."
   - 28 TAC §134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
     (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
4. On the disputed date of service, the requestor billed CPT codes 20550-78-F4 and J0702.

   HCPCS Code J0702 is described as "Injection, betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg."

   CPT Code 20550 is described as "Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia"). The requestor appended modifier 78 and F4 to code 20550.

   Modifier 78 is described as "Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period."

   Modifier F4 is described as "Left hand, fifth digit."

5. Medicare Claims Processing Manual, Chapter 12, Section 40.2 - Billing Requirements for Global Surgeries, A. Procedure Codes and Modifiers, 5. Return Trips to the Operating Room During the Postoperative Period states:

When treatment for complications requires a return trip to the operating room, physicians must bill the CPT code that describes the procedure(s) performed during the return trip. If no such code exists, use the unspecified procedure code in the correct series, i.e., 47999 or 64999. The procedure code for the original surgery is not used except when the identical procedure is repeated. In addition to the CPT code, physicians use CPT modifier "-78" for these return trips (return to the operating room for a related procedure during a postoperative period.) The physician may also need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first procedure and requires the use of the operating room, this circumstance may be reported by adding the modifier "-78" to the related procedure.

6. Medicare Claims Processing Manual, Chapter 12, Section 40.1 - Definition of a Global Surgical Package B. Services Not Included in the Global Surgical Package states:

   Treatment for postoperative complications which requires a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR).

7. The requestor billed for the disputed services with place of service 11.

   Medicare defines place of service 11-Office as "Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis."

8. The DWC finds Modifier 78 requires the procedure to be performed in an operating room. The requestor's documentation does not support the disputed treatment was performed in an operating room as described by Medicare Claims Processing Manual, Chapter 12, Section 40.1(B). The DWC concludes that the respondent's denial based upon CAC-P12, CAC-16, 225 and 892 is supported.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/16/2020 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.